U.S. Department of Labor

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Issue Date: 08 June 2007

Case Nos.: 2006-BLA-05516
2006-BLA-05517

In the Matter of

L. R. o/b/o and widow of
M. R.
Claimant

v.

DRUMMOND COMPANY, INC.
Employer/Self-Insured

and

DIRECTOR, OFFICE OF WORKERS' COMPENATION PROGRAMS
Party-in-Interest

Appearances: PATRICK K. NAKAMURA, Esq.
For the Claimant

ROBIN A. ADAMS, Esq.
For the Employer

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

DECISION AND ORDER DENYING MINER'S BENEFITS AND DENYING SURVIVOR'S BENEFITS

This proceeding arises from claims for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

On March 23, 2006, these cases were referred to the Office of Administrative Law Judges for a formal hearing (DX 69, 70).[1] Subsequently, they were assigned to me. The hearing was held before me in Birmingham, Alabama, on September 26, 2006, at which time the parties had full opportunity to present evidence and argument.

The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

A. The following issues are presented for adjudication regarding the Miner's Claim:

(1) whether the Employer was properly designated as the Responsible Operator;
(2) whether the Miner suffered from pneumoconiosis;
(3) whether his pneumoconiosis, if any, arose from coal mine employment;
(4) whether the Miner was totally disabled;
(5) whether the Miner's total disability, if any, was due to pneumoconiosis; and
(6) whether the Miner had established a change in a condition of entitlement pursuant to 20 C.F.R. § 725.309(d).

B. The following issues are presented for adjudication in the Claimant's survivor's claim:

(1) whether the Employer was properly designated as the Responsible Operator;
(2) whether the Miner had pneumoconiosis;
(3) whether the Miner's pneumoconiosis, if any, arose from his coal mine employment;
(4) whether the Miner's death was due to pneumoconiosis; and
(5) whether the Claimant has established a change in conditions or mistake in determination of a fact, as required in a request for modification under § 725.310.

II. PROCEDURAL BACKGROUND

This matter involves two claims: the Claim of the Miner, filed on October 8, 2003 (DX 4); and the survivor's claim of the Claimant, the Miner's widow, filed on May 13, 2004 (DX 41). The Miner's Claim for benefits was pending at the District Director's level when the Miner died, on April 19, 2004 (DX 16). The Claimant is the representative of the deceased Miner regarding this claim. On September 7, 2004, the District Director issued a proposed Decision and Order denying the Miner's Claim, based on a determination that, although the Miner had established that he had pneumoconiosis arising from coal mine employment, he had not established that he was totally disabled due to pneumoconiosis (DX 30). The Claimant made a timely request for a hearing (DX 31).

[1] The following abbreviations are used in this Opinion: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits; "T." refers to the transcript of the September 26, 2006 hearing.

On February 24, 2005, the District Director issued a proposed Decision and Order denying the Claimant's survivor's claim, based on a determination that the Claimant had not established any of the elements of entitlement (DX 59). The Claimant did not appeal the District Director's determination; rather, on May 31, 2005, the Claimant made a request for modification, based on her assertion that the District Director had made a mistake in determination of fact when he concluded that the Miner did not have pneumoconiosis. The Claimant also submitted additional medical evidence in support of the proposition that the Miner had pneumoconiosis (DX 60). On September 13, 2005, the District Director issued a proposed Decision and Order denying the Claimant's request for modification, based on a determination that the Miner's death was not due to pneumoconiosis (DX 63). On November 14, 2005, the Claimant submitted a second request for modification, and enclosed medical evidence to support her contention that pneumoconiosis contributed to the Miner's death (DX 64). On January 6, 2006, the District Director issued a proposed Decision and Order denying the Claimant's request for modification, based on a determination that the Miner's death was not due to pneumoconiosis (DX 66).

The Claimant timely filed a request for hearing, and her counsel requested that the two claims be consolidated for hearing (DX 67).[2] The two Claims were consolidated for hearing on March 23, 2006 (DX 71).

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Factual Background

The Miner was born in June 1934. He was married to the Claimant from 1955 to the date of his death, and had no minor children (DX 4). According to the record, the Miner was employed by the Employer at the Mulga Mine from May 1970 to July 1983. In the last year of his employment with the Employer, he was a roof bolter (February 1980 to March 1983) and a trackman (March to July 1983). The Miner was laid off in July 1983 (DX 7).

According to records maintained by the Social Security Administration, after his employment with the Employer, the Miner was employed by "DII Industries" from 1984 to 1992, and by Harbison-Walker Refactories Company, from 1992 to 1998. In 1998, the Miner was employed by "Zeeman Manufacturing Co., Inc." In 1999 and 2000, the Miner was employed by "ASI Staffing, Inc;" and in the years 2000-2002, the Miner was employed by "ADECCO" companies. The Miner's final employer, in 2002, was "Savela & Associates, Inc." (DX 9). In his Employment History, submitted in conjunction with his Claim, the Miner listed only his employment at the Mulga Mine as coal mine employment. At the request of the District Director, he provided information about his other employers, through 1998, but stated that he was not engaged in coal mine employment with any of them, and was not exposed to dust, gases, or fumes in any of these jobs (DX 5).

[2] At the request of the parties, after the Miner's Claim was referred to the Office of Administrative Law Judges for hearing, that claim was remanded to the District Director for consolidation with the Claimant's survivor's claim (DX 67).

The current claim was the Miner's third claim. His most recent previous claim was filed in July 2001 and was administratively denied in July 2002 (DX 2). In adjudicating that claim, the District Director determined that the Miner had not established any of the elements of entitlement (DX 2).

B. Claimant's Testimony

The Claimant testified under oath at the hearing. She stated that her husband worked for Mulga until 1983 or 1984, and that he did not work for any coal company after he left Mulga. She also stated that she believed that the Employer purchased the Mulga mine. The Claimant testified that her husband had cancer when he died. In the several years prior to his death, he had breathing problems. His energy level was very low, and he was unable to complete tasks without having to sit and rest, and he would get out of breath (T. at 22-26).

The Claimant testified that her husband was diagnosed with lung cancer in late 2003, about five or six months before he died. She also stated that his breathing was getting worse even before his cancer diagnosis. In particular, his energy level was very low, and he was unable to finish cutting the lawn without stopping and resting. The Claimant testified that at the time the Miner was diagnosed with cancer, his breathing was very, very shallow. He underwent chemotherapy, which seemed to help, but his worst days were the several days after the chemotherapy treatments. Then, he would get a little better, but suddenly the after effects of the chemotherapy seemed to be lasting longer. He was admitted to the hospital, and he was in the hospital for a week before he died (T. at 26-31).

On cross examination, the Claimant testified that her husband worked in a hospital, as a restaurant cook, and in offices, before he went into the mines. He also worked for Harbison Walker, a factory that makes bricks, until the end of 1997, and was pursuing a claim based on asbestos exposure. The Claimant testified that her husband retired after working at Harbison, but he was very active, so he worked at a men's clothing store as a salesman. He kept working at little jobs, because he liked to stay busy (T. at 31-35).

Upon my questioning, the Claimant stated that her husband's family physician was Dr. Richard Dale, and he had been seeing Dr. Dale for quite some time. Dr. Garcia was the doctor who oversaw her husband's chemotherapy treatments, after his cancer diagnosis. The Claimant testified that her husband's breathing took a turn for the worse in 2003, and that she did not notice that his breathing problems interfered with his ability to perform his post-retirement jobs. However, she stated, she did notice that he would be very tired when he came home, even though these jobs did not require any heavy labor. Regarding the Miner's job in the coal mines, the Claimant stated that her husband told her that he was unable to stand in the mines because the ceiling was so low. He was a rock duster, and he did a lot of heavy lifting. He worked in underground mines (T. at 36-40).

C. Responsible Operator

At the hearing, the Employer indicated that the issue of whether it was properly designated as the responsible operator remained in controversion (DX 33, 69; T. at 18-19, 41).[3]

The term "operator" is defined in § 725.491(a) as "(1) Any owner, lessee, or other person who operates, controls, or supervises a coal mine, or any independent contractor performing services or construction at such mine; or (2) Any other person who: … (iii) paid wages or a salary, or provided other benefits, to an individual in exchange for work as a miner…." Because § 725.495 states that the operator responsible for the payment of benefits shall be the potentially liable operator that most recently employed the miner, the designation of "responsible operator" is thereby limited to those entities which may be designated as "potentially liable operators." A "potentially liable operator" must have been an operator after June 1973 (§ 725.494(b)); must have employed the miner for a cumulative period of not less than one year (§ 725.494(c)); must have employed the miner for at least one day after December 1969 (§ 725.494(d)); and must be capable of assuming financial liability for the payment of benefits (§ 725.494(e)).

The record in this matter reflects that the Employer was a "potentially liable" operator and employed the Miner from 1970 to 1983 (DX 7). However, the record also reflects that the Miner worked for other employers after his employment with the Employer (DX 9). The Employer's apparent position is that it is not the Responsible Operator if any of the Miner's subsequent employers are coal mine operators (DX 13).

There is no evidence that any of the Miner's subsequent employers were coal mine operators; moreover, there is no evidence the Miner was engaged in coal mine employment after 1983. The Miner's Social Security records list his employers; after 1983, none of the employers appear to be coal mine operators (DX 9). A letter from the Employer verifies the Miner's employment at the Employer's Mulga mine from 1970 to 1983 (DX 7). At the request of the District Director, the Miner also submitted additional information about his other employers. None of his other employment involved coal mine operations (DX 5). In addition, the Miner stated in his current claim that his coal mine employment consisted only of his employment for the Employer, between 1970 and 1983; this is consistent with his assertions in his prior claims (DX 1, 2). In a prior claim, the Miner provided information about his most significant post-mining employment, from 1984 to 1998, stating that he was a kiln operator at a brick manufacturing plant (DX 2). At the hearing, the Miner's widow stated that her husband's coal mine work ended in 1983 or 1984, when the Mulga mine shut down (T. at 22-23).

Based on the foregoing, where the Employer is a potentially liable operator as defined in the regulation and where there is no evidence that the Miner had any coal mine employment after his employment with the Employer ended, I find that the Employer was properly designated as the Responsible Operator.

[3] Neither party addressed the issue in post-hearing briefs.

D. Relevant Medical Evidence

Dr. Jeffrey Hawkins conducted the evaluation of the Miner, as required under § 725.406, on November 17, 2003 (11/17/2003)(DX 12).

In general, the Claimant presented the same evidence for both the Miner's Claim and her own survivor's claim. In her affirmative case, the Claimant submitted one chest X-ray interpretation, by Dr. Miller, of the Miner's 12/16/2003 X-ray (CX 3). In rebuttal, the Claimant presented chest X-ray interpretations by Dr. Ahmed and Dr. Miller of the Claimant's 11/17/2003 X-ray (CX 1, 2). The Claimant also presented a medical report from Dr. Lott (CX 5) and medical treatment records pertaining to the Miner's treatment for lung cancer (CX 4). In support of the Claimant's requests for modification, the Claimant submitted a statement from Dr. Hawkins (DX 60).[4]

The Employer designated different items of evidence for each of the two claims. See Keener v. Peerless Eagle Coal Co., B.R.B. No. 05-1008 B.L.A. (Jan. 26, 2007)(en banc). In the Miner's Claim, the Employer presented interpretations of the Miner's 2/23/2000 and 10/12/2001 X-rays, by Dr. Sargent and Dr. Scott, respectively (DX 1, 2), as well as pulmonary function studies administered on the same dates (DX 1, 2) and an arterial blood gas study administered on 10/12/2001 (DX 2). The Employer also submitted medical reports from Dr. Goldstein, dated February 2000 (DX 1) and Dr. Russakoff, dated September 2006 (EX 1), as well as a supplemental report from Dr. Russakoff, responding to Dr. Lott's medical report and the Claimant's medical treatment records (EX 3).[5] The Employer submitted a biopsy test result from October 2003 (CX 4) and submitted the Miner's death certificate as "other evidence" under § 718.107 (DX 16, 46). In rebuttal, the Employer submitted Dr. Scott's interpretation of the Miner's 11/17/2003 X-ray (DX 14) and Dr. Wheeler's interpretation of the Miner's 12/16/2003 X-ray (EX 2).[6]

For the Claimant's survivor's claim, the Employer presented all of the evidence that it presented for the Miner's claim, except for Dr. Goldstein's medical report, which was not included.

These items will be discussed in greater detail below.

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[4] In the Claimant's second request for modification, Claimant's counsel stated that he intended to submit a statement from Dr. Lott, but did not do so prior to the District Director's action (DX 64). I presume that the statement from Dr. Lott submitted at the hearing is the statement to which Claimant's counsel refers.

[5] The Employer submitted EX 3 on October 26, 2006, pursuant to my ruling at the hearing (T. at 16-17). Although EX 3 is dated July 2006, that date is clearly erroneous because the report refers to correspondence dated September 2006.

[6] The Employer submitted this item in response to my Order of November 20, 2006, in which I granted in part and denied in part the Employer's "Motion to Exclude Evidence and/or for Leave to Submit Additional Evidence out of Time," filed on September 20, 2006.

E. Issues involving Medical Evidence

After the hearing was held in these claims, the Benefits Review Board issued its Decision in Keener v. Peerless Eagle Coal Co., B.R.B. No. 05-1008 B.L.A. (Jan. 26, 2007)(en banc). In Keener, the Board reiterated its holding, enunciated in Church v. Kentland-Elkhorn Coal Corp., B.R.B. Nos. 04-0617 B.L.A. and 04-0617 B.L.A.-A (Apr. 28, 2005), that evidence from a living miner's claim must be designated as evidence by one of the parties in order for it to be considered in the survivor's claim; in addition, the Board held that the administrative law judge should consider the evidence on the specific issues of entitlement in each claim, and in accordance with the evidentiary limitations for each claim.

Based on the Keener decision, on March 20, 2007, I issued a "Notice to Parties Regarding Consideration of Evidence; and Order to File Objections or Request Consideration of Additional Evidence." In this Notice, I informed the parties, among other things, that I would consider medical evidence contained in the Miner's Claim in adjudicating the Claimant's claim only if that evidence was designated by one of the parties. I also provided the parties the opportunity to object to my determinations, or to designate additional evidence from the Miner's claim for consideration in the Claimant's Claim.

In response to my Order, the Employer reiterated its position, from its prehearing motion, objecting to my consideration of the X-ray interpretations the Claimant submitted in rebuttal. In addition, the Employer also objected to my consideration of these X-ray interpretations, which were not interpretations of the same X-rays the Employer submitted in its affirmative case. Citing Keener for the proposition that the regulations require rebuttal evidence to "analyze or interpret the evidence to which it is responsive," the Employer asserted that the Claimant's rebuttal X-rays, from 11/17/2003, do not analyze or interpret its X-ray interpretations of 2000 and 2001 X-rays.

I disagree with the Employer's interpretation of Keener. First, as the Employer concedes, Keener deals with autopsy results, not X-rays. See § 725.414(a)(2) and § 725.414(a)(3). Generally speaking, there is only one autopsy involved in any particular case, so it would follow that any rebuttal autopsy report would analyze or interpret the same autopsy presented by the opponent in its affirmative case. Consequently, the language in Keener, while perfectly appropriate when discussing the parties' abilities to submit affirmative and rebuttal autopsy reports, may not apply with regard to X-rays, where multiple X-rays of the same miner, taken on different dates, are the rule.

Second, the Employer's position ignores the Board's holding in Sprague v. Freeman United Coal Mining Co., B.R.B. No. 05-1020 B.L.A. (Aug. 31, 2006). In Sprague, the Board stated: "Thus, we hold that rebuttal evidence submitted by a party pursuant to 20 C.F.R. § 725.414(a)(2)(ii), (a)(3)(ii), need not contradict the specific item of evidence of which it is responsive, but rather, need only refute "the case" presented by the opposing party." Id., at 6. Unlike Keener, Sprague did concern X-ray interpretations, so its holding is directly on point. Moreover, Sprague was decided a few months before Keener, so the Board's holding in Keener must be read in light of its earlier decision in Sprague.

Therefore, based on the Board's decisions, I find that the Claimant's rebuttal X-rays (CX 1 and CX 2) are properly admitted, and I will consider them.

E. Subsequent Miner's Claim

Because this claim is a subsequent claim, it must be denied unless the Claimant can demonstrate that one or more applicable conditions of entitlement have changed since the denial of the prior claim, in 2002. § 725.309(d). However, if the Claimant establishes a change in one or more of the conditions of entitlement, he still bears the burden of proving the remaining conditions of entitlement. § 725.309(d)(4). See National Mining Ass'n v. Dep't of Labor, 292 F.3d 849, 861 (D.C. Cir. 2002).

As § 725.309(d) states, the following rules pertain to the adjudication of subsequent claims:

> (1) Any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim;
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. . . .[I]f the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously;
>
> (3) If the applicable conditions of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement . . . .

F. Entitlement – Miner's Claim

Because this claim was filed after January 19, 2001, the Claimant's entitlement to benefits is evaluated under the revised regulations set forth at 20 C.F.R. Part 718. The Act provides for benefits for miners who are totally disabled due to pneumoconiosis. § 718.204(a). In order to establish an entitlement to benefits under Part 718, the Claimant bears the burden to establish the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled; and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

1. Elements of Entitlement:

Pneumoconiosis Defined:

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine

employment." This definition includes both medical or "clinical" pneumoconiosis, and statutory, or "legal" pneumoconiosis, which themselves are defined in that subparagraph at (1) and (2). "Clinical" pneumoconiosis consists of diseases recognized by the medical community as pneumoconioses, characterized by permanent deposition of substantial amounts of particulates in the lungs, and the fibrotic reaction of the lung tissue, caused by dust exposure in coal mine employment. "Legal" pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. Further, § 718.201(b) states: "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

a. Whether the Miner had Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§ 718.202(a)(1) through (a)(4):

(1) X-ray evidence: § 718.202(a)(1).
(2) Biopsy or autopsy evidence: § 718.202(a)(2).
(3) Regulatory presumptions: § 718.202(a)(3).[7]
(4) Physician opinion based upon objective medical evidence: § 718.202(a)(4).

X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with § 718.102 may form the basis for a finding of the existence of pneumoconiosis. ILO Classifications 1, 2, 3, A, B, or C shall establish the existence of pneumoconiosis; Category 0, including subcategories 0/0 and 0/1, do not establish pneumoconiosis. Category 1/0 is ILO Classification 1.

[7] These are as follows: (a) an irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis (§ 718.304); (b) where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment (§ 718.305); or (c) a rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971 (§ 718.306).

The current record contains the following chest X-ray evidence:

Date of X-Ray	Date Read	Ex.No.	Physician	Radiological Credentials[8]	Interpretation
02/23/2000	03/07/2000	DX 1	Sargent	BCR, B reader	ILO: Neg. for pneumoconiosis. Box checked: "OD" [other significant abnormality]. Narrative comment: "smoking history?"
10/12/2001	03/04/2002	DX 2	Scott	BCR, B reader	ILO: Neg. for pneumoconiosis. Box checked: "OD." Narrative comment: "Few scars periphery RUL [right upper lung] and possibly left mid-lung compatible with healed infection"
11/17/2003	11/25/2003	DX 12	Ballard	B reader[9]	ILO: 1/0, 6 lung zones, t/q.[10] Narrative comments: "There are no pleural plaques, pleural thickenings or pleural calcifications. No parenchymal infiltrates, nodules, or masses are seen….The above parenchymal changes are consistent with Coalworkers (sic) pneumoconiosis provided the subject's exposure history and period of latency are appropriate"
11/17/2003	08/03/2006	CX 1	Ahmed	BCR, B reader	ILO: 2/1, 6 lung zones, q/t. Boxes checked: "ax" "em" "id" "ih." Narrative comments: "Minute soft rounded and irregular parenchyma densities measuring up to 3 mm. are seen scattered throughout both lungs. No evidence of localized pneumonia …. There is coalescence of small pneumoconiotic opacities. There are changes of chronic obstructive pulmonary disease. Pleural thickening is seen along the right and left lateral chest walls en face.... Impression: Simple pneumoconiosis category q/t, 2/1…. Emphysema (em). Indistinct

[8] A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. See generally: http://www.answers.com/topic/radiology#after_ad1. A B reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services. See 42 C.F.R. § 37.51 for a general description of the B reader program.

[9] This information appears on Dr. Ballard's letterhead (DX 12).

[10] Although this report uses the International Labour Organization (ILO) terminology, it was not submitted on the NIOSH form but was in a narrative format.

					diaphragm (id). Indistinct heart border (ih). Coalescence of small pneumoconiotic opacities (ax)."
11/17/2003	08/14/2006	CX 2	Miller	BCR, B reader	ILO: 2/1, 6 lung zones, t/q. Boxes checked: "ax" "em" "ih." Narrative comments: "There are multiple bilateral small irregular and round opacities ranging in size up to approximately 3 mm. There are no large opacities. There is coalescence of small pneumoconiotic opacities. There are changes of chronic obstructive pulmonary disease…." Impression: Findings consistent with simple pneumoconiosis, category t/q, profusion 2/1. Chronic obstructive pulmonary disease (em). Coalescence of small pneumoconiotic opacities (ax). Ill defined heart outline (ih)."
12/16/2003	08/14/2006	CX 3	Miller	BCR, B reader	ILO: 2/1, 6 lung zones, t/q. Boxes checked: "ax" "em" "ih." Narrative comments: "There are multiple bilateral small irregular and round opacities ranging in size up to approximately 3 mm. There are no large opacities. There is coalescence of small pneumoconiotic opacities. There are changes of chronic obstructive pulmonary disease…. Impression: Findings consistent with simple pneumoconiosis, category t/q, profusion 2/1. Chronic obstructive pulmonary disease (em). Coalescence of small pneumoconiotic opacities (ax). Ill defined heart outline (ih)."
12/16/2003	01/11/2007	EX 2	Wheeler	BCR, B reader	Neg. for pneumoconiosis. Boxes checked: "aa" "em?" "pl" "tb?". Narrative comments: "Minimal to moderate mixed irregular and small nodular infiltrates or fibrosis lower posterolateral RUL involving pleural compatible with granulomatous disease, TB, or histoplasmosis….Probable emphysema ….Subtle linear interstitial infiltrate or interstitial fibrosis ….compatible with usual interstitial pneumonitis or autoimmune disease….focus arteriosclerosis aortic arch….subtle arteriosclerosis aortic arch….No CWP [coal workers' pneumoconiosis] which should give symmetrical small nodular infiltrates in central mid and upper lungs, not unilateral nodules in lower lateral RUL involving pleura (which has no alveoli)."

It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34

(1985). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984).

The X-ray record in this claim consists of four X-rays, all taken within a four-year span (2000 to 2003). Two of the X-rays, those from 2000 and 2001, were read as negative for pneumoconiosis by dually-qualified physicians. The November 2003 X-ray has three readings, all positive for pneumoconiosis; two of these readings are from dually-qualified physicians, and one is from a B reader. The December 2003 X-ray has been interpreted as positive for pneumoconiosis by a dually-qualified physician and also has been interpreted as negative for the disease by a dually-qualified physician.

For the purpose of determining the X-ray evidence, in general I give more weight to the opinions of physicians who are Board-certified radiologists and B readers than I do to the opinions of physicians who are not Board-certified radiologists but are B readers. I give more weight to the opinions of the former because they have wide professional training in all aspects of X-ray interpretation. I give equal weight to all physicians who possess the same professional credentials (for example, all Board-certified radiologists).

Regarding the Miner's X-rays, I find that there is some evidence of pneumoconiosis, in that dually-qualified physicians have concluded that there is X-ray evidence of the disease. I also note, however, that dually-qualified physicians have concluded that there is no evidence of pneumoconiosis based on X-rays. Although all of the X-rays are within a short timeframe, the most recent X-ray was interpreted as both positive and negative for the disease by dually-qualified physicians. Consequently, I conclude that the X-ray evidence of pneumoconiosis is in equipoise. I find, therefore, that the Claimant has not established that the Miner had pneumoconiosis, based on X-ray.

Biopsy or Autopsy Evidence

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). The Miner's medical treatment records, submitted by the Claimant, include the report of a biopsy of the Miner's right lung, upper lobe, conducted in October 2003 (CX 4).[11] The medical treatment records recount the Miner's treatment for lung cancer, from October 2003 to April 2004, and consist primarily of medical treatment notes and laboratory reports.

The lung biopsy report, titled "Surgical Pathology" consists of a gross description, microscopic examination, and diagnosis. The diagnosis was "small cell malignant neoplasm." An addendum report, on the same page, confirmed the diagnosis. The report does not mention

[11] The Employer submitted the biopsy results in its affirmative case. See Employer's pre-hearing statement.

pneumoconiosis in any way. Nor does it mention any other lung ailment. The report is signed by Dr. Paul Biggs, a member of the Department of Pathology at Baptist Princeton Medical Center, Birmingham, Alabama.

Under § 718.106(c), a negative biopsy is not conclusive evidence that a miner does not have pneumoconiosis. However, positive findings constitute evidence of the presence of pneumoconiosis. Because this biopsy does not mention pneumoconiosis in any way, I find that it has little value in determining whether the miner had pneumoconiosis.

Regulatory Presumptions

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 applies only in cases of deceased miners who died before March 1, 1978. Since none of these presumptions applies in this case, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

Physician Opinion

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth in subparagraph (a)(4): A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989). Generally, a medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields, supra. An opinion based on a physical examination, symptoms, and a patient's work and social histories may be found to be adequately documented. Hoffman v. B. & G Construction Co., 8 B.L.R. 1-65 (1985).

The record contains the following medical opinions:[12]

Dr. Allen Goldstein (DX 1)

Dr. Goldstein, who is Board-certified in internal medicine and pulmonary disease, conducted an evaluation of the Miner in February 2000, in conjunction with the Miner's initial claim for benefits, and submitted a report on Department of Labor forms.[13] Dr. Goldstein's evaluation included a physical examination, medical and work histories, and various medical tests, including an electrocardiogram, pulmonary function test, arterial blood gas test, and chest X-ray.

In his examination of the Miner, Dr. Goldstein noted that the Miner reported dyspnea and attacks of wheezing, the latter since 1996. The Miner also reported a smoking history of 24 years, at the rate of one pack per day, ending in 1980, and a coal mine employment history of approximately 13 years in underground mines, ending in 1983. Dr. Goldstein's physical examination of the Miner did not yield any abnormal pulmonary symptoms; the Miner's blood pressure was measured at 150/100 in both arms.

Dr. Goldstein diagnosed the Miner with dyspnea, and attributed the Miner's condition to coronary artery disease, and also possibly to his high blood pressure. Dr. Goldstein did not make any conclusion regarding whether the Miner had any degree of impairment, and noted that the Miner's pulmonary function tests (PFTs) were normal.

Dr. Jeffrey Hawkins (DX 12)[14]

Dr. Hawkins, who is Board-certified in internal medicine, pulmonary disease, and critical care medicine, conducted the evaluation of the Miner under § 725.406 in November 2003, in connection with his most recent claim for benefits, and submitted a report on Department of Labor forms. This evaluation took place shortly after the Miner was diagnosed with lung cancer, and Dr. Hawkins' report reflects the diagnosis. Dr. Hawkins' evaluation included a physical examination, medical and work histories, and various medical tests, including a chest X-ray, a pulmonary function test, and an arterial blood gas test. After Dr. Hawkins conducted the evaluation and submitted his report to the Department of Labor, a different physician invalidated the Miner's pulmonary function tests, because the variance between successive trials exceeded

[12] This portion of my Decision also includes a summary and discussion of the Miner's medical treatment records.

[13] Dr. Goldstein's professional credentials are not a matter of record. By Order dated May 23, 2006, the parties were informed that I may utilize the internet to obtain information about a physician's professional qualifications, and that parties who had not provided such information were deemed to have waived any objection.

[14] The Claimant also submitted a supplemental statement from Dr. Hawkins, in the Claimant's survivor's claim (DX 60).

the regulatory limit. The Miner then underwent a second pulmonary function test, in February 2004. However, Dr. Hawkins did not submit a new report.[15]

The Miner reported to Dr. Hawkins that he had dyspnea and, among other things, could "barely" walk up one flight of stairs. The Miner also reported nonspecific chest pain and chronic bronchitis, as well as a history of high blood pressure. In his physical examination of the Miner, Dr. Hawkins noted slight cachexia, and also noted abnormalities on auscultation of the lungs.[16] The Miner's blood pressure was 96/50 in one arm and 94/50 in the other. The report reflects the Miner's employment history of approximately 13 years in underground mines, ending in 1983, as well as a smoking history that began at age 20 and ended in 1980, at the rate of a pack per day.

Dr. Hawkins made the following diagnoses: restrictive lung disease, based on dyspnea and spirometry; pneumoconiosis, based on dyspnea, abnormal X-ray and history of exposure; and lung cancer, by history.[17] Dr. Hawkins also concluded that the Miner had a moderate respiratory impairment and could not perform manual labor, due to his exertional dyspnea; also, Dr. Hawkins recommended that the Miner avoid exposure to chemicals, dust, and fumes. Regarding the etiology of the Miner's impairment, Dr. Hawkins ascribed 70% of the impairment to restrictive lung disease, and 30% to pneumoconiosis.

Dr. James Lott (DX 16, 46; CX 5)[18]

Dr. Lott, who is Board-certified in internal medicine and pulmonary disease, treated the Miner from at least 1998 through 2002. The record includes approximately 70 pages of treatment records from Dr. Lott, detailing the Miner's treatment.[19] These records include treatment notes, as well as reports of various medical tests, including X-rays, CT scans, a biopsy, and pulmonary function tests.

The medical treatment records deal with the Miner's referral to Dr. Lott, in 1998, from his primary care physician, for dyspnea. Dr. Lott evaluated the Miner and administered various tests, including pulmonary function tests and several CT scans of the chest. A biopsy/bronchoscopy was performed in 1998. These records reflect that in 2002, the Miner returned to Dr. Lott, because his symptoms had worsened. Dr. Lott conducted more tests.

In 2001, Dr. Lott wrote a medical report summarizing the Miner's condition. In that report, Dr. Lott stated that the Miner had interstitial disease, based upon the findings of a high-

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[15] Dr. Hawkins signed the second pulmonary function test report, so it is apparent that he knew of the re-testing.

[16] The notation includes an arrow (↓), indicating a diminishment in function, but is otherwise not legible.

[17] Dr. Hawkins relied on an X-ray interpretation by Dr. James Ballard, a B reader.

[18] Neither party mentioned DX 16 or DX 46 in the pre-hearing statements. However, medical treatment records are admissible without limitation, under § 725.414(a)(4).

[19] DX 46 appears to be a duplicate of DX 16. DX 46 was submitted in the Claimant's survivor's claim; DX 16 was submitted in the Miner's claim. I will consider these records in determining the elements of both the Miner's claim and the Claimant's survivor's claim.

resolution chest CT. This report noted that the Miner had a history of dust exposure, and so his condition could be an occupationally related lung disease.

Dr. Lott's 2002 treatment notes indicate that the Miner's interstitial disease had advanced, based on objective test results. In particular, Dr. Lott noted a progression of diffuse pulmonary fibrotic disease. Dr. Lott's overall impressions included pneumoconiosis and interstitial lung disease.

Of particular note in Dr. Lott's treatment records are reports of several chest CT scans, two in 1998 and one in April 2002. The first scan in 1998 reflects "minimal fibrotic changes in the lungs;" the second, one month later, reflects "interstitial fibrosis" and "mild fibroemphysematous change." The April 2002 CT report states "there has been progressive interstitial fibrotic change and alveolar septal thickening since the prior examination. Some peripheral honeycombing is now seen as well." Additionally, the report stated that no lung nodular masses were seen. Based on these observations, the interpreting physician opined that the Miner had "progressive diffuse pulmonary fibrosis."

Dr. Lott's treatment records also contain a biopsy report, apparently from a bronchoscope procedure the Miner underwent in December 1998. The biopsy report reflected acute inflammation, but did not mention any other lung condition. Lastly, these records include CT scans and an office note from October 2003, reflecting the Miner's cancer diagnosis. These records, apparently generated by Dr. Dale, reflect that the Miner was again referred to Dr. Lott, and was also referred to an oncologist for treatment.

At the hearing, the Claimant's counsel submitted CX 5, which consists of Dr. Lott's responses to three questions. The questions, and Dr. Lott's responses, are as follows:

1. *Did [the Miner's] exposure to coal mine dust contribute to or cause the respiratory problems you treated him for?* Yes

2. *Did [the Miner's] respiratory problems contribute to OR hasten his death by compromising his lungs and leaving him less able to survive the lung cancer that caused his death?* Yes

3. *Did [the Miner's] respiratory problems render him ineligible from any treatments combating lung cancer that would likely have extended his life?* No

Dr. David Russakoff (EX 1, 3)

At the request of the Employer, Dr. Russakoff, who is Board-certified in internal medicine and pulmonary disease and is a B reader, examined medical records pertaining to the Miner and, in September 2006, submitted a written report. The principal evidence Dr. Russakoff analyzed were treatment records from Dr. Lott, covering the period from 1998 to 2002, and the

Miner's pulmonary evaluations, including those conducted by Dr. Goldstein in 2000 and Dr. Hawkins in 2003.[20]

Dr. Russakoff's report includes five single-spaced pages summarizing the records he examined. Then, Dr. Russakoff provided commentary and responses to specific questions. In his commentary, Dr. Russakoff noted that the Miner was suspected, as far back as 1998, of having "some kind of interstitial lung disease." According to Dr. Russakoff, the various readings on chest X-rays were "moot" because a high resolution CT scan in April 2002 showed no lung nodules present. Then in 2003, the Miner developed lung cancer which, in Dr. Russakoff's opinion, was most consistent with a diagnosis of small cell carcinoma. By the time of his diagnosis the Miner already had liver metastases.

The questions posed to Dr. Russakoff, and his responses, are summarized as follows:

1. Did [the Miner] have pneumoconiosis at the time of his death?

No, based on the accumulated evidence, especially the high-resolution CT scan. In addition, up until he was diagnosed with lung cancer, physical examinations of the Miner showed him to be free of pulmonary abnormalities.

2. Was [the Miner's] death caused by pneumoconiosis, or was pneumoconiosis a substantial contributing cause of his death?

No. Pneumoconiosis was not present, and so it could not have caused the Miner's death or been a factor in his death.

3. Was [the Miner's] death caused by interstitial pulmonary fibrosis or was that condition a substantial contributing cause of his death?

No. Although the evidence strongly suggests that some form of interstitial pulmonary fibrosis was present, the probable cause of the Miner's death was his lung cancer. The normal course of such extensive cancer, despite chemotherapy, is often not longer than six months.

After the hearing, the Employer submitted a supplement to Dr. Russakoff's report, consisting of Dr. Russakoff's comments upon review of the report from Dr. Lott (discussed above) and the records from Dr. Garcia, the Miner's oncologist (discussed below) (EX 3). Dr. Rusakoff stated that there was nothing that would alter his previous conclusions, and pointed out that the records "do not indicate any concern about the status of his respiratory condition other than as related to the cancer in his lung and its response to his chemotherapy regimen."

[20] Dr. Russakoff's opinion also refers to pulmonary function tests and X-ray interpretations that have not been admitted. To the extent that Dr. Russakoff relies on evidence not admitted, I disregard his remarks. See § 725.414(a)(3)(i).

Miner's Other Medical Treatment Records (CX 4)

At the hearing, the Claimant submitted approximately 70 pages of medical records detailing the Miner's cancer treatment. These records include treatment notes of Dr. Garcia, the Miner's Board-certified oncologist, as well as X-ray reports and other medical test results. Several of the X-rays appear to have been administered in conjunction with the Miner's hospitalization, in the week before his death. Several CT reports, some of which indicate that the Miner's lung cancer had metastasized, are also included.

Dr. Garcia's treatment notes chronicle the Miner's treatment from November 2003, shortly after he was diagnosed with lung cancer, to April 2004, when the decision was made to admit the Miner to the hospital. Dr. Garcia's first treatment note includes a notation that the median survival rate for small-cell lung cancer improves, with treatment, from six weeks up to six to eight months. His second treatment note indicates that the Miner had evidence of bony metastases.

The Miner began a course of chemotherapy under Dr. Garcia's supervision and was tolerating treatment well, except for gastrointestinal side effects and possible anemia, until mid-April 2004. The most recent treatment note indicates that on April 12, 2004, Dr. Garcia saw the Miner and noted diarrhea, severe weakness and fatigue. The treatment note states that the Miner was admitted to the hospital for IV fluids and hydration.

The Miner's Death Certificate (DX 16, 46)

The Employer submitted the Miner's death certificate as "other medical evidence" under § 718.107 for consideration in both the Miner's claim and the Claimant's survivor's claim. Dr. Garcia, the Miner's treating oncologist, signed the death certificate, which listed "lung cancer" as the sole cause of the Miner's death on April 19, 2004.

The Employer did not articulate any "good cause" why the Miner's death certificate should be considered in the Miner's claim. Although the Claimant did not object to my consideration of this item, I find that it is of no relevance in determining whether the Miner suffered from pneumoconiosis. Therefore, I will disregard the Miner's death certificate in the determination of the Miner's claim. However, as the Miner's death certificate is certainly relevant in the Claimant's survivor's claim, I will consider it regarding the cause of the Miner's death. Further discussion of this item appears below.

Discussion

In sum, the record includes opinions from four Board-certified pulmonary specialists. Two of these specialists, Dr. Hawkins and Dr. Lott, have opined that the Miner had pneumoconiosis. The others, Dr. Goldstein and Dr. Russakoff, have opined that he did not.

Dr. Lott's opinion, contained primarily in the medical report presented at the hearing (CX 5), but also in the medical treatment records (CX 16, 46), is generally stated in conclusory or equivocal terms. For example, in his medical report at CX 5, Dr. Lott indicated his concurrence

with a statement that the Miner's exposure to coal mine dust contributed to or caused the respiratory problems for which he was treated, but Dr. Lott did not indicate the basis for this conclusion. Additionally, Dr. Lott's medical report, dated 2001, indicated Dr. Lott's conclusion that the Miner had interstitial disease, based on CT test results, and noted that the Miner had an occupational history of dust exposure, but concluded that the Miner's interstitial disease "may be" related to his occupational exposure. Consequently, I find Dr. Lott's opinion not to be well-reasoned, and I give it little weight.[21]

Dr. Hawkins also concluded that the Miner had pneumoconiosis, based on the Miner's symptoms ("dyspnea"), a chest X-ray interpretation, and the Miner's history of exposure. The chest-X-ray Dr. Hawkins relied upon, taken 11/17/2003, showed evidence of the disease, and the Miner's dyspnea and coal mine employment history are both reflected on Dr. Hawkins' written report (DX 12). Dr. Hawkins also found some abnormalities on physical examination. I find Dr. Hawkins' opinion to be well-reasoned, based on the evidence before him, and I give it substantial weight.[22]

Dr. Goldstein's report reflected the Miner's history of coal mine employment, and also recorded that the Miner had a mild degree of hypoxemia. However, Dr. Goldstein's opinion does not explain why he excluded pneumoconiosis as a diagnosis in light of these facts. The regulation recognizes that pneumoconiosis can be present, even in the absence of a positive chest X-ray. See § 718.202(a)(4). Consequently, I find Dr. Goldstein's opinion not to be well-reasoned, and I give it little weight.

Based on an examination of medical records only, Dr. Russakoff concluded that the Miner did not have pneumoconiosis. Dr. Russakoff seemed to be most persuaded by the Miner's high-resolution CT scan of April 22, 2002, included in the Miner's medical treatment records, which indicated interstitial lung disease ("progressive diffuse pulmonary fibrosis") but did not find any evidence of lung nodular masses. According to Dr. Russakoff, if the Miner had pneumoconiosis, the CT would have shown such masses. Dr. Russakoff also was aware that the Miner had chest X-rays interpreted as positive for pneumoconiosis.

I find Dr. Russakoff's opinion that the Miner did not have pneumoconiosis, based primarily on the fact that no nodular masses were seen on a high-resolution CT scan, to be well-reasoned, and I give it substantial weight. Although Dr. Russakoff did not take into consideration the qualifications of Dr. James Walker, the physician who interpreted the CT scans, Dr. James Walker, and Dr. Walker's qualifications are not in the record, I presume that

[21] In concluding that Dr. Lott's opinion should be given little weight, I have considered Dr. Lott's status as the Miner's treating physician, as required by § 718.104. Dr. Lott's status as the Miner's treating physician does not overcome the deficiencies in his reports, notably, that they are conclusory or equivocal regarding pneumoconiosis.

[22] I note that Dr. Hawkins also was aware that the Miner had recently been diagnosed with lung cancer, and presume that he took that diagnosis into consideration when making his diagnosis.

Dr. Russakoff inferred that this physician, who also interpreted other CT scans in the Miner's medical treatment records, was a radiologist.[23]

As the discussion above indicates, the two physicians to whom I give the most weight, Dr. Hawkins and Dr. Russakoff, differ in their opinions regarding whether the Miner has pneumoconiosis. Consequently, I must conclude that the existence of pneumoconiosis has not been established, based on physician opinion. Considering all of the evidence pertaining to this issue, including the chest X-ray evidence and the evidence contained in the Miner's medical treatment records, I find that the Claimant has not established, by a preponderance of evidence, that the Miner had pneumoconiosis.

b. Whether the Miner's Pneumoconiosis "Arose out of" Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. § 718.203(b).

In this case, the record establishes that the Claimant has more than ten years of coal mine employment. Therefore, he is entitled to the rebuttable presumption. However, as set forth above, I find that the Claimant has failed to establish that he has pneumoconiosis. Consequently, he is unable to benefit from this presumption.

c. Whether the Miner was Totally Disabled

The Claimant bears the burden to establish that the Miner was totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) states that a miner shall be considered totally disabled "if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner: (i) from performing his or her usual coal mine work; or (ii) from engaging in gainful employment . . . requiring the skills and abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." Nonpulmonary and nonrespiratory conditions, which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. § 718.204(a). See also Beatty v. Danri Corp., 16 B.L.R. 1-11 (1991).

The regulation provides that, in the absence of contrary probative evidence, the following may be used to establish a miner's total disability: pulmonary function tests with values below a specified threshold; arterial blood gas tests with results below a specified threshold; a finding of pneumoconiosis with evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(i)(ii) and (iii). Where the above do not demonstrate total disability, or appropriate medical tests are contraindicated, total disability may nevertheless be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and

[23] James C. Walker, Jr. is a Board-certified diagnostic radiologist in Birmingham, Alabama. See fn. 13, supra., regarding professional qualifications and the internet.

laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment. § 718.204(b)(2)(iv).

Pulmonary Function Tests

The record contains the following pulmonary function test results:[24]

Date of Test	Physician	FEV_1	FVC	MVV	FEV_1/FVC ratio	Valid ?
09/15/1998	Lott	2.40	2.59	69	93%	Yes
02/23/2000	Goldstein	3.31	3.79	117	87%	Yes
10/12/2001	Shad	3.21	4.01	123	80%	Yes
04/17/2002	Lott	2.45	2.77	81	88%	No[25]
10/22/2003	Lott	1.67	2.12	63	79%	No[26]
11/17/2003	Hawkins	1.98	2.54	71	78%	No[27]
02/06/2004	Hawkins	2.58	3.12	110	83%	Yes

In order to demonstrate total respiratory disability on the basis of the pulmonary function tests, the studies must, after accounting for gender, age, and height, produce a qualifying value for the forced expiratory volume [FEV_1] test and at least one of the following: a qualifying value for the forced vital capacity [FVC] test; a qualifying value for the maximum voluntary volume [MVV] test; or a value of the FEV_1 divided by the FVC that is less than or equal to 55%. § 718.204(b)(2)(i). "Qualifying values" for the FEV_1, FVC, and the MVV tests are results measured at less than or equal to the values listed in the appropriate tables of Appendix B to Part 718.

The Miner was born in June of 1934, so he ranged in age from 64 to 69 years old at the time these tests were performed. His height was variously listed at 72 inches (5 tests), 70.5 inches (1 test), and 71 inches (1 test). I find, therefore, that the Miner was at least 71.6 inches tall, which is the weighted average of the reported heights. For a male of this height, the qualifying FEV_1 values are as follows, by age:

Age	64	65	66	67	68	69
FEV_1	2.09	2.07	2.06	2.04	2.02	2.01

[24] The Miner's medical treatment records also contain references to additional pulmonary function tests. I have considered these test results in my Decision (DX 16, 46). However, because no additional documentation regarding these tests is included in the record, I am unable to determine the validity of these tests. Consequently, I give them minimal weight.

[25] This test was administered in conjunction with medical treatment and consisted of fewer than three complete trials (DX 16, 46). See Appendix B to part 718.

[26] This test was administered in conjunction with medical treatment and consisted of fewer than three complete trials (DX 16, 46). See Appendix B to part 718.

[27] This test was invalidated at the District Director's level due to excessive variation between trials and suboptimal MVV performance (DX 12).

The only pulmonary function tests for which the Miner attained a qualifying FEV_1 value were the tests administered in October and November 2003, at about the time he received his lung cancer diagnosis. At that time, the Miner was 69 years old. At that age, the qualifying value for the FEV_1 test is 2.01; he attained values of 1.67 and 1.98. For both of those tests, the Miner attained qualifying values for the FVC and MVV tests, as the qualifying values for those tests are 2.58 and 80, respectively, and his scores did not reach those thresholds.

However, the weight that I assign to these tests is minimal, because neither of the two tests was valid. The Miner's October 2003 test, administered as part of medical treatment, did not have the requisite number of trials required under Appendix B to part 718 of the regulations, and the Miner's November 2003 test was invalidated because the variation in values attained exceeded the regulatory limits. I note also that the Miner did not attain a qualifying FEV_1 value on the test administered several months later, in February 2004, a test which was valid.

Considering the fact that the majority of the Miner's pulmonary function tests did not reflect qualifying FEV_1 values, and that the only two tests on which the Miner attained a qualifying value were of minimal utility because they were not valid, I find that the Claimant is unable to establish that the Miner was totally disabled, based on pulmonary function test results.

Arterial Blood Gas Tests

The record contains the following arterial blood gas test results:

Date of Test	Physician	PCO_2	PO_2	PCO_2 (post-exercise)	PO_2 (post-exercise)
10/12/2001	Shad	40.3	77.8	39.0	79.6
11/17/2003	Hawkins	22	98	19	87

A Claimant may also establish total disability based upon arterial blood gas tests. In order to establish total disability, the test must produce a qualifying value, as set out in Appendix C to Part 718. § 718.204(b)(2)(ii). Appendix C lists values for percentage of carbon dioxide [PCO_2] and percentage of oxygen [PO_2], based upon several gradations of altitudes above sea level. At a specified gradation (e.g., 2999 feet above sea level or below), and PCO_2 level, a qualifying value must be less than or equivalent to the PO_2 listed in the table.

At an altitude of 2999 feet or less, the altitude at which the Miner's tests were administered, the qualifying PO_2 values for the PCO_2 values he registered are as follows:

Measured PCO_2 value	PCO_2: 40.3	PCO_2: 39.0	PCO_2: 22	PCO_2: 19
Qualifying PO_2 value	PO_2: 60	PO_2: 61	PO_2: 75	PO_2: 75
Miner's PO_2 value	PO_2: 78	PO_2: 79.6	PO_2: 98	PO_2: 87

Based on the foregoing, it is clear that the Miner did not attain a qualifying score on any arterial blood gas test. Therefore, I find that the Claimant is unable to establish that the Miner was totally disabled under this provision.

Cor Pulmonale

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(iii). As stated above, I did not find that the Claimant had established that the Miner had pneumoconiosis. Moreover, there is no evidence of cor pulmonale with right-sided congestive heart failure. Accordingly, I find that the Claimant has not established total disability under this provision.

Physician Opinion

The final method of determining whether the Miner is totally disabled is through the reasoned medical judgment of a physician that the Miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable gainful employment. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Fields v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. An unreasoned or undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (1989). A physician's opinion must demonstrate an adequate understanding of the exertional requirements of the Miner's coal mine employment. Brigance v. Peabody Coal Co., B.R.B. No. 05-0722 B.L.A. (June 29, 2006)(en banc).

The only physician who rendered an opinion whether the Miner was totally disabled was Dr. Hawkins, who examined the Miner in November 2003, as required under § 425.406. In his written report, Dr. Hawkins diagnosed the Miner with a moderate restrictive impairment, based upon the pulmonary function study. Dr. Hawkins then stated that the Miner could not perform manual labor, due to exertional dyspnea. In addition, Dr. Hawkins attributed the majority of the Miner's disability, 70%, to his restrictive lung impairment.

The Miner's summary of his coal mine employment history, which reflected that the Miner's last coal mine employment was as an underground miner and that he worked as a roof bolter, among other things, was appended to Dr. Hawkins' report. It is reasonable to conclude, therefore, that Dr. Hawkins had an adequate understanding of the exertional requirements of the

Miner's job. However, the record reflects that Dr. Hawkins' undated report was received at the District Director's office in December 2003, and that thereafter the pulmonary function test upon which Dr. Hawkins based his conclusions was invalidated. The Miner underwent a new pulmonary function study, in February 2004, under Dr. Hawkins' supervision. As noted above, the February 2004 pulmonary function study yielded significantly different results, which were non-qualifying for disability. However, the record does not include any updated report from Dr. Hawkins taking into consideration the new pulmonary function study results.

Dr. Hawkins' conclusion that the Miner was totally disabled was due in part to an invalidated pulmonary function study. Moreover, Dr. Hawkins concluded that the restrictive impairment demonstrated in that pulmonary function study constituted the principal cause of the Miner's disability. Because the only opinion of Dr. Hawkins that is contained in the record is based on faulty data, I find that it is not well-reasoned, and I give it little weight. I also find that Dr. Hawkins' conclusion is not well-reasoned because it presumes that the Miner had pneumoconiosis, and I have found to the contrary. Even assuming arguendo that Dr. Hawkins' conclusion that the Miner had pneumoconiosis is correct, I reject his conclusion that 30% of the Miner's disability is due to the disease, because Dr. Hawkins fails to provide any reason or rationale for this determination. As this opinion is conclusory, I find it is not well-reasoned, and give it little weight.[28]

Although the record contains other medical opinions, none of them focus on the issue of whether the Miner was totally disabled from coal mine employment, from a pulmonary perspective. Consequently, I cannot give any weight to any of these opinions.

Based on the foregoing, I conclude that the Claimant is unable to demonstrate, by a preponderance of evidence, that the Miner was totally disabled, due to a respiratory impairment. In making this conclusion, I also have considered evidence based on pulmonary function and arterial blood gas tests, and note that the weight of this evidence does not establish disability either.

d. Whether the Miner's Disability was Due to Pneumoconiosis

Lastly, the Claimant must establish that the Miner was totally disabled due to pneumoconiosis. This element is fulfilled if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the Miner's totally disabling respiratory or pulmonary impairment. § 718.204(c); Consolidation Coal Co. v. Williams, 453 F.3d 609 (4th Cir. 2006); Lollar v. Alabama By-Products Corp., 893 F.2d 1258 (11th Cir. 1990). The regulations provide that pneumoconiosis is a "substantially contributing cause" of a miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition or materially worsens

[28] I also am concerned that Dr. Hawkins' opinion does not discuss the role of the Miner's lung cancer. The record reflects that the Miner's lung cancer was diagnosed in October 2003, about a month before Dr. Hawkins' evaluation. Dr. Hawkins' report reflects that he knew about the Miner's lung cancer. Yet, unless Dr. Hawkins concluded that the Miner's restrictive lung impairment was due to his cancer (which Dr. Hawkins does not explicitly state), Dr. Hawkins did not consider the impact, if any, of the Miner's lung cancer on his respiratory condition.

a totally disabling respiratory or pulmonary impairment caused by a disease or exposure unrelated to coal mine employment. In general, the fact that an individual suffers or suffered from a totally disabling respiratory or pulmonary impairment is not, in itself, sufficient to establish that the impairment is or was due to pneumoconiosis. § 718.204(c)(2). A Claimant can establish this element through a physician's documented and reasoned medical report. § 718.204(c).

As noted above, Dr. Hawkins attributed 70% of the Miner's disability to restrictive lung disease, and 30% to pneumoconiosis. However, Dr. Hawkins' conclusion was based, at least in part, on an invalid pulmonary function study. In addition, although Dr. Hawkins also relied in part on a positive chest X-ray interpretation, I have found that the Claimant is unable to establish, by a preponderance of evidence, that the Miner had pneumoconiosis.

Even if I presume, contrary to my finding, that the Miner had pneumoconiosis, I cannot conclude that Dr. Hawkins' conclusion regarding the relative contribution of each condition to the Miner's disability was well-reasoned, because it is clear that this conclusion was based in part upon the invalidated pulmonary function study. Although it is clear that Dr. Hawkins was aware of the Miner's second pulmonary function test, in February 2004, because Dr. Hawkins' signature appears on the test report, it is not clear whether his opinion regarding the etiology of the Miner's impairment remained the same. I find, therefore, that Dr. Hawkins' opinion is not well-reasoned, and I give it little weight.

Based on the foregoing, where the Claimant has not established that the Miner was totally disabled, and where the only opinion of record regarding disability is based in part on an invalidated test, I must conclude that the Claimant is unable to establish, by a preponderance of evidence, that the Miner's disability was due to pneumoconiosis.

H. Subsequent Claim

The Claimant has failed to establish, by a preponderance of evidence, any of the elements of entitlement that previously had been adjudicated against the Miner, in his earlier claims. Therefore, this Claim must be denied. § 725.309(d).

I. Entitlement – Request for Modification of Survivor's Claim

The Act provides for benefits to eligible survivors of deceased miners whose death was due to pneumoconiosis. § 718.205(a). Eligible survivors may include the miner's widowed spouse. § 725.201(a)(2). Under § 718.205, where there is no miner's claim filed prior to January 1, 1982 resulting in entitlement to benefits, a survivor who files a claim after January 1, 1982 is entitled to benefits only upon demonstrating that the miner died due to pneumoconiosis. In order to establish entitlement to benefits in a survivor's claim filed on or after January 1, 1982, a claimant must establish three elements by a preponderance of the evidence: (1) that the miner had pneumoconiosis; (2) that the miner's pneumoconiosis arose out of coal mine employment; and (3) that the miner's death was due to pneumoconiosis. § 718.205(a)(1) through (3). Trumbo v. Reading Anthracite Co., 17 B.L.R. 1-85 (1993). The Claimant has the burden to establish each element of entitlement. OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

In addition, the Claimant's current claim is a request for modification of her initial survivor's claim, which has twice been administratively denied (DX 63, 66). The regulation at § 725.310(c) provides that "[i]n any case forwarded for hearing, the administrative law judge assigned to hear such case shall consider whether any additional evidence submitted by the parties demonstrates a change in condition and, regardless of whether the parties have submitted new evidence, whether the evidence of record demonstrates a mistake in a determination of fact."

In determining whether a "change in conditions" is established, the fact-finder must conduct an assessment of the newly submitted evidence (all evidence submitted subsequent to the prior denial) and consider it in conjunction with the previously submitted evidence to determine if the weight of the new evidence is sufficient to demonstrate an element or elements of entitlement previously adjudicated against the claimant. Kingery v. Hunt Branch Coal Co., 19 B.L.R. 1-6 (1994). Even if a "change in conditions" is not established, evidence in the entire claim file must be considered to determine whether a "mistake in a determination of fact" was made. This is required even where no specific mistake of fact has been alleged. Kingery, supra. Moreover, a mistake of fact may be "demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." Zurat v. Director, OWCP, B.R.B. No. 98-1075 B.L.A. (May 4, 1999).

1. Whether the Miner had Pneumoconiosis

In a survivor's claim, it must first be determined whether the miner suffered from coal workers' pneumoconiosis before a finding may be made regarding the etiology of his death. Trumbo v. Reading Anthracite Co.,17 B.L.R. 1-85 (1993).

2. Whether the Miner's Pneumoconiosis arose out of Coal Mine Employment

In a survivor's claim, the presumption regarding the etiology of pneumoconiosis set forth in § 718.203(b) also applies. That is, if it is established that a Miner has ten or more years of coal mine employment, the Miner is entitled to the rebuttable presumption that his pneumoconiosis arose from coal mine employment.

3. Whether the Miner's Death was Due to Pneumoconiosis

For claims filed on or after January 1, 1982, § 718.205(c) provides the criteria for determining whether a miner's death is due to pneumoconiosis. This section requires that the Claimant establish one of the following:

(a) competent medical evidence establishes that pneumoconiosis was the cause of the miner's death;

(b) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death, or where the death was caused by complications of pneumoconiosis; or

(c) where the presumption set out at § 718.304 [complicated pneumoconiosis] applies. Trumbo v. Reading Anthracite Co., 17 BLR 1-85 (1993); Neely v. Director, OWCP, 11 BLR 1-85 (1988); Boyd v. Director, OWCP, 11 BLR 1-39 (1988).

The regulation provides that pneumoconiosis is a "substantially contributing cause" of a miner's death if it "hastens the miner's death." § 718.205(c)(5). The regulation also cautions, however, that survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of the Miner's death. § 718.205(c)(4).

Discussion

As set forth above, upon consideration of all of the evidence submitted, I have found that the Claimant was unable to establish, by a preponderance of evidence, that the Miner had pneumoconiosis.[29] In my consideration, I included the items of evidence that had been submitted after the most recent denial of the Claimant's claim, which were the chest X-ray interpretations the Claimant submitted at the hearing (CX 1, 2, 3), as well as the Miner's medical treatment records and Dr. Lott's medical report (CX 4, 5). I also considered Dr. Hawkins' supplemental statement (DX 60).[30]

Because the Claimant has not established that the Miner had pneumoconiosis, it is not necessary to examine whether the Claimant has established the remaining elements of entitlement.

However, assuming arguendo that the Miner did have pneumoconiosis, the evidence the Claimant has presented regarding the cause of the Miner's death does not establish that pneumoconiosis played any role in his death, let alone that pneumoconiosis was a "substantially contributing cause" of his death. The principal evidence the Claimant presented regarding the cause of the Miner's death was Dr. Lott's medical report (CX 5). This report states only Dr. Lott's concurrence with a statement that the Miner's "respiratory problems" contributed to his death "by compromising his lungs and leaving him less able to survive the lung cancer that caused his death." Because Dr. Lott did not provide any rationale for his conclusion, I find his opinion not to be well-reasoned, and I give it little weight. In addition, although Dr. Lott was the Miner's treating physician for a significant period of time, Dr. Lott appears not to have treated the Miner in the year before his death, and he did not sign the Miner's death certificate.[31] Although medical records detailing the Miner's cancer treatment were presented (at CX 4), these records detail the Miner's treatment with Dr. Garcia, an oncologist, and not Dr. Lott. The Miner's course of treatment in the hospital, and contemporaneous notes regarding the proximate cause of the Miner's death in the hospital, are not matters of record.

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[29] In this regard, I did not consider Dr. Goldstein's report (DX 1), which was not offered by any party for consideration in the Claimant's survivor's claim. See Keener v. Peerless Eagle Coal Co., B.R.B. No. 05-1008 B.L.A. (Jan. 26, 2007)(en banc).

[30] Dr. Hawkins' supplemental statement, dated February 2006 (DX 60), relates to the Miner's respiratory impairment, and is of little value in determining the elements of the Claimant's survivor's claim.

[31] The Miner's death certificate, signed by Dr. Garcia, lists "lung cancer" as the sole cause of death. No autopsy was performed (DX 16, 46).

Sadly, it appears from the records presented that the Miner's death, six months after his lung cancer diagnosis, was consistent with Dr. Garcia's estimate of the length of his survival, made at the time the cancer was diagnosed. Although it appears that the Miner was making good progress with his chemotherapy until very shortly before his death, the medical treatment notes do not indicate that he had any respiratory problems that complicated his treatment or hastened his death. Rather, the treatment notes seem to indicate that the Miner suffered from gastrointestinal complications.

Because my examination of the entirety of the evidence indicates that the Claimant has not established any of the elements of entitlement, it is unnecessary for me to examine the evidence to determine whether the Claimant has established a change in conditions. I also have examined the record established with regard to the Claimant's survivor's claim, and have not discerned any mistake in determination of fact.[32]

IV. CONCLUSION

Based upon applicable law and my review of all of the evidence, I find that the Claimant has not established any entitlement to benefits under the Act. My finding extends to both the Miner's claim and the Claimant's survivor's claim.

V. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which a Claimant is represented by counsel and is found to be entitled to benefits under the Act. Because benefits were not awarded in this Claim, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the Claim.

VI. ORDER

The Claimant's Claims for benefits under the Act are DENIED.

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Adele H. Odegard
Administrative Law Judge

Cherry Hill, New Jersey

[32] As the Claimant's counsel pointed out in the first request for modification, in the initial adjudication of the Claimant's survivor's claim the District Director mistakenly concluded that the Miner did not have pneumoconiosis, contrary to a prior conclusion, made during administrative adjudication of the Miner's claim, that the Miner had established that element of entitlement (DX 30). This mistake in determination of fact was corrected during the administrative adjudication of the Claimant's first request for modification (DX 63).

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).